Physical Examination QualChart®

Illinois Valley Community Hospital

* Printed: 10/4/2016 15:56
Time/Date Seen (If Different):

Mode of Arrival: ☐ EMS ☐ Other

Instructions: Circle pertinent positive findings. Exclude pertinent negative findings. INDICATORS: ✱ = ID ▲PQRS

Vital Signs: Stable except: BP _____ Pulse _____ R Rate _____ Temp _____

Pulse Ox: Normal Hypoxic Not Applicable _____ % on Room Air or O_2 @ _____ L/min

Cardiac Monitor: Rate: NSR Brady Tachy Rhythm: Sinus Afib Junctional **Ectopy:** None PVCs PACs

HISTORY:

HX from Patient Unobtainable due to: Dementia Altered Mental Status Extremis Other: _____

HX from: Patient Family / Caretaker EMS Interpreter Caseworker LMP: _____

CHIEF COMPLAINT: This is a 3 (year old) male / (female) who presents for a physical examination for School Work (DCFS) (Circle if Appropriate)

Any Complaints: Yes / (No) wellness check.

pt has no complaint. pt taken away from mother due to alleged allegation against mother.

ONSET/DURATION Started _____ Min Hours Days Weeks Ago Still Present Resolved Worse Since: _____

TIMING Constant Intermittent Episodes Lasting _____ Sec Min Hours Days Weeks

SEVERITY Initially: Mild Moderate Severe Currently: Mild Moderate Severe

LOCATION

CHARACTER

AGGRAVATING

ALLEVIATING

ASSOCIATED SIGNS AND SYMPTOMS Negative

RELATED HX Abuse No Other Known History - Patient in DCFS Custody

REVIEW OF SYSTEMS:

Pertinent Positives

Constitutional	Neg	Fever	Chills
Eyes	Neg	Photophobia	Blurred Vision
ENT	Neg	Sore Throat	Ear Ache
CV	Neg	Palpitations	Chest Pain
Resp	Neg	SOB	Cough
GI	Neg	Vomiting	Diarrhea
GU	Neg	Dysuria	Hematuria
MSkeletal	Neg	Arthralgia	Myalgia
Skin	Neg	Rash	Bruising
Neuro	Neg	Headache	Weakness
Psych	Neg	Anxious	Depressed

All other systems reviewed and negative: (Yes) No

Levels 2 - 3: 1 System Level 4: 2 Systems Level 5: 10 Systems / Disclaimer

Additional Pertinent History:

PCP / Managing Physician(s):

Referred to ED / Clinic by: PCP / Telephone Referral / Other:

Previous Visit for Same Complaint to ED / Clinic / PCP / In-Patient Within 72 Hours / _____ Days Dx / Rx:

DCFS want a physical exam.

Pt active, playful.

Rx/Treatment Compliant

PAST MEDICAL HISTORY:

(Previously Healthy) DNR / Comfort Care Only

PMH / FH / SH: Levels 1 - 3: 0 Level 4: 1 Level 5: PMH plus FH or SH

Endocrine	DM I	DM II	Hypothyroid	Hyperthyroid	Dyslipidemia			
CV	CAD / MI	HTN	CHF	Afib	DVT			
Respiratory	COPD	Asthma	Bronchitis	Pneumonia	PE			
GI / GU	PUD / GERD	GI Bleed	Urosepsis	Diverticulitis	Gall / Kidney Stones	Chronic Kidney Dx		
Neuro / Psych	TIA / CVA	Migraine	Anxiety	Depression	Seizure	Bipolar Disorder	Schizophrenia	PTSD
Cancer	Lung	Colon	Breast	Prostate				
Surgical Hx	None	Unknown						

Immunizations: Unknown Tetanus UTD Not UTD

✱ Pneumococcal ✱ Influenza within 12 months

FAMILY HISTORY:

(Negative)

Heart / HTN _____

Diabetes _____

Other: _____

SOCIAL HISTORY:

(Negative)

Smoking _____ ppd x _____ yrs. ✱ Patient Advised to Stop

Cessation Counseling Time: 3+ min - 10 min / 10+ min.

✱ ETOH / Drug Use _____

Occupation: _____

Lives: Alone (With Family) At Nursing Home

KRAMER, MADELINE H
VISIT ID: 11216788
01/20/2013 3Y/F
ATT: SABIR, MUHAMMAD
PCP: OUT OF TOWN, PHYSICIAN
MRN: 261617

DATE 10/18/2016

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PHYSICAL EXAMINATION: EXAM LIMITED DUE TO: Dementia Altered Mental Status Extremis Other: _____

		Normal Findings:	Abnormal Findings:
			Complaint-Specific Findings
Appearance	Normal	Well-Appearing No Pain Distress Well-Nourished	Ill-Appearing: Mild Mod Severe Pain Distress: Mild Mod Severe Obese / Thin / Cachectic
Eyes	Normal	PERL / EOMI Conjunctiva Clear	R Pupil _____ L Pupil _____ Conjunctiva Inflammed
ENT	Normal	Ears Normal Nose Normal Oropharynx Normal	TMs Occluded Rhinorrhea / Epistaxis Erythema / Exudate / Dry Mucosa
Neck	Normal	Supple	Nonsupple
Respiratory	Normal	Airway Patent CTA Breath Sounds Equal Respiration Nonlabored	Airway Obstructed Crackles @ _____ Rhonchi @ _____ Wheezes @ _____ Retractions
Cardiovascular	Normal	RRR Pulses Normal No Rub / Murmur	IRR Tachycardia Bradycardia Abn. Pulses @ _____ Murmur
GI / GU	Normal	Soft / Nontender No Masses Bowel Sounds Normal No Organomegaly	Tender @ _____ Mass @ _____ Bowel Sounds Hypo Hyper Hepatomegaly / Splenomegaly
Musculoskeletal	Normal	Strength / ROM Intact No Edema No Calf Tenderness	Limited @ _____ Edema @ _____ Calf Tenderness
Skin	Normal	Warm & Dry Color Normal	Pale / Diaphoretic Cyanosis @
Neuro	Normal	Sensory / Motor Intact Reflexes Intact CN Intact A&O x3	Focal Deficit @ _____ Abn. Reflex @ _____ CN _____ Palsy A V P U Disoriented
Psychiatric	Normal	Affect / Mood Appropriate	Anxious / Depressed

Level 1: 1 System Level 4: 4 Systems
Levels 2 - 3: 2 Systems Level 5: 8 systems

DIFFERENTIAL DIAGNOSES: Consideration of the following conditions may be warranted for the presenting problem; they are not final diagnoses.

RE-EVALUATION: Pain Scale (0-10)

Time: _____ Unchanged Improved Worse VSS

Time: _____ Unchanged Improved Worse VSS

PHYS. NOTIFICATION/CONSULTS: *Chart Copy Available to Addt'l Care Providers*

Discussed disposition/case/management of patient with:

Name D/C Pt Custody at _____ a.m. / p.m.

Name _____ at _____ a.m. / p.m.

Admit/Transition Orders Written by ED Provider: Yes / No

Reviewed with: _____

Admit to: _____ Consult Follow-up: _____

DISPOSITION: *DISPOSITION DECISION TIME: _____

Discharge: Home Work Nursing Home Deceased AMA *LWBS

Admit: ED Obs InPt Unit: ICU OR Tele Floor Condition: Stable Unstable

Patient Endorsed To/Discussed With: _____ @ _____ a.m. / p.m.

Patient Stabilized Within Hospital's Capabilities/Transferred to: _____

_____ Transfer Form Completed

Disposition Rationale: _____

Discussed with: Patient Family Other: _____

After-Care Instructions Given to & Follow-Up Care Discussed w/Patient At Discharge

ED PHYSICIAN DIAGNOSES:

1 Normal Peds Exam.

2

3

Critical Care Provided: 30-74 min / 75-104 min / _____ min (Excludes time required for other billable procedures)

SIGNATURE: I have reviewed available Ancillary / Nursing Staff documentation.

TIME: _____ PA / NP / Resident

DATE (if different than above): _____ MD/DO

_____ MD/DO

Teaching Physician - I performed a history & physical examination of the patient and discussed the management with the Resident. I reviewed the Resident's note and agree with the findings and plan of care, except as I have documented. _____ (Initials)

Chart Completed: Yes No

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This form is to assist the healthcare provider's documentation of clinical care and treatment. It is not intended to supplant that judgement or create a standard of care.

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